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THE USE OF ALTERNATIVES TO INSTITUTIONALIZATION OF THE MENTALLY ILL

by

Daniel W. Shuman* and Richard Hawkins**

I. INTRODUCTION

A. *Therapeutic Aspects of Institutional Care*

From the development of psychiatric hospitals or institutions in the United States in the early nineteenth century¹ until very recently,² hospitalization or institutionalization has been the primary mode of care and treatment for the mentally ill in public psychiatry. Although the creation of institutions for the insane and the provision of institutional care was once viewed as a progressive approach to the care and treatment of the mentally ill, it is now commonly accepted that alternatives to institutional care for the mentally ill are frequently more effective than institutional care,³ and that institutional care should be used only as a treatment of last resort.⁴

The change in attitude towards institutional care is a result of the discovery of the deleterious effects of institutionalization,⁵ the discovery of new medications,⁶ and the development of community based mental

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1. See D. ROTHMAN, *THE DISCOVERY OF THE ASYLUM* 130-54 (1971).

2. See A. SCULL, *DECARCERATION* (1977); Kaplan, *State Control of Deviant Behavior: A Critical Essay on Scull's Critique of Community Treatment and Deinstitutionalization*, 20 ARIZ. L. REV. 189 (1978). It is not coincidental that the American Psychiatric Association's predecessor organization was the Association of Medical Superintendents of American Institutions for the Insane founded in 1844.

3. See, e.g., A. DAVIS, B. DINITZ & B. PASAMANICK, *SCHIZOPHRENICS IN THE NEW CUSTODIAL COMMUNITY: FIVE YEARS AFTER THE EXPERIMENT* (1974); Langsley, Machotka & Flomenhaft, *Avoiding Mental Hospital Admission: A Follow-Up Study*, 127 AM. J. PSYCH. 1391, 1394 (1971).

4. Position Statement on Involuntary Hospitalization of the Mentally Ill, 128 AM. J. PSYCH. 1480, 1480 (1972).

5. E. GOFFMAN, *ASYLUMS* 350 (1961); Mendel, *Effect of Length of Hospitalization on Rate and Quality of Remission from Acute Psychotic Episodes*, 143 J. NERVOUS & MENTAL DISEASE 226 (1966). In addition to the dependency fostered by this form of care, most public mental hospitals have been overcrowded, underfunded, and inadequately staffed. Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1107, 1125-50 (1970).

6. Jarvick, *The Psycho Pharmacological Revolution*, in *READINGS IN CLINICAL PSYCHOLOGY TODAY* 93 (1970).

health programs and facilities.⁷ The efficacy of community care is evidenced by numerous studies. For example, several studies involving the treatment of comparable groups of schizophrenics in mental hospitals and at home show that the schizophrenics treated at home had fewer hospital readmissions and better mental status than those treated in mental hospitals.⁸ Day hospitalization,⁹ adult foster care,¹⁰ half-way houses,¹¹ and boarding homes¹² have also been shown effective in the treatment of mental disorders.

B. *The Doctrine of Less Drastic Means*

The doctrine of separation of powers,¹³ which allocates the law-making function to the legislature, carries with it an implicit limitation upon the judicial power to scrutinize the means the legislature has chosen to resolve certain societal problems.¹⁴ Typically, the mere existence of a rational basis for legislation has been sufficient to limit further judicial inquiry into the wisdom of that legislative choice.¹⁵ One exception to this general rule of limited judicial scrutiny is the doctrine of less drastic means.¹⁶ This doctrine precludes the government's use of overly broad means of accomplishing its valid objectives if the broad approach restricts certain protected interests and a less drastic means of accomplishing the government's objective exists.¹⁷ The United States Supreme Court has described the doctrine as follows:

In a series of decisions this Court has held that, even though the

7. Greenblatt & Glazier, *The Phasing Out of Mental Hospitals in the United States*, 132 AM. J. PSYCH. 1135 (1975).

8. See A. DAVIS, B. DINITZ & B. PASAMINICK, *supra* note 3.

9. Herz, Endicott, Spitzer & Mesnikoff, *Day Versus Inpatient Hospitalization: A Controlled Study*, 127 AM. J. PSYCH. 1371 (1971).

10. Brook, Cortes, March & Sundberg-Stirling, *Community Families: An Alternative to Psychiatric Hospitalization*, 27 HOSPITAL & COMMUNITY PSYCH. 195 (1976).

11. H. GOTTSFELD, ALTERNATIVES TO PSYCHIATRIC HOSPITALIZATION 49 (1977).

12. *Id.* at 47.

13. The doctrine of separation of powers contemplates a division of functions between the legislative, judicial, and executive branches of government to avoid the consolidation of power in any one branch. J. NOWAK, R. ROTUNDA & J. YOUNG, CONSTITUTIONAL LAW 126-27 (1978). For a discussion of the evolution of the separation of powers theory, see Sharp, *The Classical American Doctrine of "The Separation of Powers,"* 2 U. CHI. L. REV. 385 (1935). See generally A. VANDERBILT, THE DOCTRINE OF THE SEPARATION OF POWERS AND ITS PRESENT-DAY SIGNIFICANCE (1953). See also *Nixon v. Administrator of Gen. Serv.*, 433 U.S. 425 (1977).

14. "Whether wisdom or unwisdom resides in [legislation], it is not for us to say. The answer to such inquiries must come from Congress, not the courts. Our concern here, as often, is with power, not with wisdom." *Helvering v. Davis*, 301 U.S. 619, 644 (1936) (Justice Cardozo).

15. See, e.g., *Williamson v. Lee Optical*, 348 U.S. 483 (1955). In cases in which the law infringes on constitutionally protected rights, a stricter scrutiny is applied. See, e.g., *Roe v. Wade*, 410 U.S. 113 (1973).

16. Wexler & Scoville, *Special Project—The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1, 140 (1971). See also Chambers, *supra* note 5; Hoffman & Foust, *Least Restrictive Treatment of The Mentally Ill: A Doctrine in Search of Its Senses*, 14 SAN DIEGO L. REV. 1100 (1977); *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190 (1974).

17. Wexler & Scoville, *supra* note 16, at 140.

governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgment must be viewed in the light of less drastic means for achieving the same basic purpose.¹⁸

Although the Court has not articulated clear guidelines for application of this doctrine,¹⁹ its application to civil commitment proceedings is compelling.²⁰ Protection of society from the dangerous mentally ill, protection of the mentally ill from themselves, and the rendition of beneficial treatment to the mentally ill have been recognized as valid governmental objectives.²¹ If the government seeks to accomplish these objectives through involuntary hospitalization, it restricts a protected interest, liberty,²² and if an alternative form of care (*e.g.*, outpatient care) would be as effective²³ and less restrictive of the patient's liberty, involuntary hospitalization should not be permitted.²⁴

The first judicial recognition of the less drastic means doctrine in the mental health area occurred in *Lake v. Cameron*,²⁵ a decision of the District of Columbia Circuit Court of Appeals authored by Judge David Bazelon. Mrs. Lake suffered from "senile brain disease" and had been confined to St. Elizabeth's Hospital because of her inability to care for herself. In an opinion that reviewed a challenge to her confinement, Judge Bazelon interpreted the relevant District of Columbia statute to require judicial exploration and exclusion of less restrictive alternatives as a prerequisite to involuntary hospitalization.²⁶ The opinion indicates that application of the less drastic means doctrine in civil commitment proceedings is supported by the United States Constitution as well as by the District of Columbia Code.²⁷

Lake was cited by the United States Supreme Court in *In re Gault*²⁸ as support for the "possible duty of a trial court to explore alternatives to involuntary commitment in a civil proceeding."²⁹ The Court, however, subsequently dismissed for want of a substantial federal question the appeal in *Sanchez v. New Mexico*,³⁰ a case that raised the *Lake* issue in a

18. *Shelton v. Tucker*, 364 U.S. 479, 488 (1960).

19. *Chambers*, *supra* note 5, at 1145.

20. *See* note 16 *supra*.

21. *Addington v. Texas*, 99 S. Ct. 1804, 1809, 60 L. Ed. 2d 323, 331 (1979).

22. 99 S. Ct. at 1809, 60 L. Ed. 2d at 331.

23. A. DAVIS, B. DINITZ & B. PASAMANICK, *supra* note 3.

24. An objective analysis of restrictiveness may be inappropriate. For example, a patient who requires some form of inpatient care may find the open ward of a state hospital with large grounds less restrictive of his liberty than a nursing home with closed wards and no grounds. Because it is the patient's interest in liberty that the doctrine seeks to take into account, the court's or the expert's notions of restrictiveness must be tempered by the patient's view. *Hoffman & Foust*, *supra* note 16, at 1104.

25. 364 F.2d 657 (D.C. Cir. 1966).

26. *Id.* at 659-61.

27. *Id.* at 659-60. *See also* *Covington v. Harris*, 419 F.2d 617 (D.C. Cir. 1969).

28. 387 U.S. 1 (1967).

29. *Id.* at 28 n.41.

30. 80 N.M. 438, 457 P.2d 370 (1969), *appeal dismissed*, 396 U.S. 276 (1970).

constitutional setting. Because the dismissal implies that the Court found a constitutional question lacking, *Sanchez* might be interpreted as the demise of the constitutional doctrine of less drastic means in civil commitment proceedings. Nonetheless, numerous subsequent lower federal decisions have found constitutional support for the doctrine in civil commitment proceedings.³¹ These decisions recognize that the Court had previously decided the issues presented in other cases dismissed for want of a substantial federal question;³² therefore, the precedential value of the Court's refusal to hear *Sanchez* is limited.³³

Subsequent pronouncements by the Court also suggest that it may be willing to reexamine the issue at a later date. In *Jackson v. Indiana*,³⁴ for example, the Court examined the constitutionality of a lengthy commitment for incompetency to stand trial, and noted that "[a]t the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed."³⁵ Arguably, if outpatient treatment is the most efficacious mode of treatment, and the commitment is not to protect society from this patient, inpatient treatment lacks a reasonable relationship to the purpose for which the individual was committed.

In *O'Connor v. Donaldson*,³⁶ in the context of a discussion of the right to liberty, the Court stated that "incarceration is rarely if ever a necessary condition for raising the living standards of those capable of surviving safely in freedom, on their own or with the help of family or friends."³⁷ Standing alone, this statement might be subjected to a variety of interpretations; however, as authority for this proposition the *O'Connor* Court cited *Shelton v. Tucker*,³⁸ a case in which the Court applied the less drastic means doctrine to protect a teacher's freedom of association. The plaintiff in *Shelton* challenged an attempt by Arkansas to discover its teachers' organizational ties in order to ascertain their fitness as teachers.³⁹ Although the Court recognized that inquiry into teacher fitness is a legitimate state goal, it concluded that requiring teachers to disclose all their organizational ties interfered with a constitutionally protected interest, and that the state's legitimate goals could be accomplished through narrower or less

31. *Stamus v. Leonhardt*, 414 F. Supp. 439, 453 (S.D. Iowa 1976); *Lynch v. Baxley*, 386 F. Supp. 378, 392 (M.D. Ala. 1974); *Davis v. Watkins*, 384 F. Supp. 1196, 1203 (N.D. Ohio 1974); *Welsch v. Likins*, 373 F. Supp. 487, 502 (D. Minn. 1974); *Lessard v. Schmidt*, 349 F. Supp. 1078, 1095-96 (E.D. Wis. 1972), *vacated on other grounds and remanded*, 414 U.S. 473, *judgment modified on other grounds and reinstated*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated on other grounds and remanded*, 421 U.S. 957 (1975).

32. *E.g.*, *Welsch v. Likins*, 373 F. Supp. 487, 501 (D. Minn. 1974).

33. See Note, *Summary Disposition of Supreme Court Appeals: The Significance of Limited Discretion and a Theory of Limited Precedent*, 52 B.U.L. REV. 373 (1972).

34. 406 U.S. 715 (1972).

35. *Id.* at 738.

36. 422 U.S. 563 (1975).

37. *Id.* at 575.

38. 364 U.S. 479 (1960).

39. *Id.* at 488.

drastic means.⁴⁰ The *O'Connor* Court's reference to *Shelton* in conjunction with a statement about avoiding unnecessary incarceration may therefore be viewed as another indication of the Court's willingness to consider application of the less drastic means doctrine in civil commitment proceedings.

*Parham v. J.R.*⁴¹ is further evidence of the Court's willingness to apply this doctrine to commitment proceedings. *Parham* held that due process requires only an independent professional review of a child's admission to a mental hospital rather than an adversarial proceeding.⁴² One aspect of the professional review that appeared to weigh heavily in the Court's decision was the state's attempt to treat children in the community prior to a mental hospital referral.⁴³ In effect, Georgia required the use of less drastic alternatives, and the Court's opinion may be viewed as another positive response to the doctrine.

Jackson v. Indiana, *O'Connor v. Donaldson*, and *Parham v. J.R.* therefore indicate that the Supreme Court may be willing to hold that the doctrine of less drastic means is constitutionally mandated in civil commitment proceedings. The resolution of this constitutional question, however, need not stall use of the doctrine in civil commitment proceedings. Since noninstitutional care may be more effective than institutional care in some cases, common sense dictates that noninstitutional care be ruled out before the state orders institutional care. Moreover, the use of the least restrictive form of care offers hope of a workable compromise between opponents and proponents of civil commitment.⁴⁴ Noninstitutional care, when feasible, avoids many of the objections that opponents of civil commitment have made.⁴⁵ Patients are not confined to large public institutions in conditions that may approximate criminal confinement; their treatment is not hidden from public scrutiny by removal from the mainstream of society; if an error in diagnosis or commitment is made, community care is usually less onerous than the state hospital; and use of community care still per-

40. *Id.* at 486-87. *Shelton* is one of the cases that has been relied upon by those who advocate application of the doctrine in civil commitment proceedings. See, e.g., Wexler & Scoville, *supra* note 16, at 141.

41. 99 S. Ct. 2493, 61 L. Ed. 2d 101 (1979).

42. *Id.* at 2506, 61 L. Ed. 2d at 121-22.

43. *Id.* at 2500, 61 L. Ed. 2d at 113-14.

44. Chambers, *supra* note 5, at 1111. See also A. STONE, MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION 43 (1975) ("[T]he best remedy for reducing wholesale involuntary confinement is good treatment in a decent local facility. . . ." (Emphasis original)).

45. One commentator has written:

With few exceptions [public mental hospitals] suffer from woeful understaffing, overcrowding, and physical decay. . . . Even if states devoted greater resources to improving hospital care, there are certain dangers to the isolation of hospitals that improved staffing cannot cure. Nearly all long-term hospital patients exhibit flatness of response, withdrawal, muteness, and loss of motivation. Once believed to be part of the degenerative process of mental illness, these phenomena are now universally accepted—even by public hospital administrators—as responses to hospitalization itself superimposed on the difficulties of illness.

Chambers, *supra* note 5, at 1125-27. See also Livermore, Malmquist & Meehl, *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75 (1968).

mits the state an effective means of accomplishing its objectives. Thirty-five states have found either the legal or policy arguments compelling: twenty state commitment statutes expressly refer to the use of less drastic alternatives, and another fifteen impliedly refer to the use of less drastic alternatives.⁴⁶

Texas is one state that did not wait for litigation to prompt its adoption of a statute providing for court-ordered alternatives to institutional care. House Bill 917, introduced in the sixty-fourth session of the Texas Legislature, was passed without opposition.⁴⁷ It is codified in section 38(c) of the Texas Mental Health Code, which became effective September 1, 1975.⁴⁸ Section 38(c) provides:

If upon the hearing the court finds that the proposed patient is mentally ill and requires observation or treatment for his own welfare and protection or the protection of others but that the required observation or treatment can be accomplished without commitment to a mental hospital, the court may order the proposed patient to submit to other treatment, observation, or care as may be found by the court to be likely to promote the welfare or protection of the proposed patient and the protection of others. If the proposed patient fails to fulfill the terms of the court's order, the court may, on its own motion or on the motion of any interested party, order that the mentally ill person be committed as a patient for observation or treatment in a mental hospital for a period not exceeding 90 days.

Section 38(c) does not, on its face, require the examination or use of the least restrictive alternative; instead, it states that "the court *may* order" the use of alternatives. Furthermore, this section does not provide a time limit for commitment to an alternative treatment setting, nor does it prescribe procedures for revocation of a commitment order entered under this section. No enumeration of alternatives is contained in the statute. The parties and the court apparently are limited only by their own creativity in considering alternatives. The statute makes no reference to funding of alternative modes of care, nor is there a provision requiring the alternative treatment agency to accept a section 38(c) commitment.

The ambiguities of the statute were perhaps intended to allow maximum flexibility for the judges and to acknowledge the great variation in availability of alternative resources in different counties. Yet these ambiguities make it almost impossible to predict the effect that section 38(c) will have on the civil commitment process in Texas.

The effect of this section is of significant consequence. Although alternatives to institutional care have been recognized as viable therapeutic

46. Hoffman & Foust, *supra* note 16, at 1113 nn.48 & 49.

47. 1975 Tex. Gen. Laws, ch. 209, § 1, at 486. Interview with Rep. John W. Bryant, sponsor of H.B. 917, Sept. 26, 1979, Dallas, Texas. The bill was introduced at the request of a probate judge who concluded that the then existing statutes provided him with insufficient flexibility in civil commitment proceedings. Telephone interview with Judge David Jackson, Sept. 27, 1979, Dallas, Texas.

48. TEX. REV. CIV. STAT. ANN. art. 5547—38(c) (Vernon Supp. 1980).

choices,⁴⁹ there is evidence that as many as half the people who are confined to state hospitals could be effectively treated elsewhere.⁵⁰ Is this inappropriate placement in whole or in part a result of the failure to adopt and apply the less drastic means doctrine to civil commitment proceedings? Is the time and expense entailed in litigation or lobbying for the doctrine justified? Or is adoption of the doctrine only a hollow promise of community mental health care? The following study, funded by the Hogg Foundation for Mental Health, is a first step in ascertaining the impact of section 38(c).

C. *The Study*

The study was an empirical one, partially based on first-hand observation of actual commitment proceedings controlled by section 38(c). The first part of the study involved a detailed examination of the commitment process in Dallas County, Texas. After receiving permission from the judge who is assigned primary responsibility for the civil commitment docket,⁵¹ we attended all commitment hearings scheduled during a ten-week period in the summer of 1979.⁵² In addition to observing these hearings, we conducted extensive interviews with judges, prosecutors, defense attorneys, social workers, psychiatrists, and other mental health personnel involved in the commitment process.⁵³

Because commitment procedures and the availability of alternatives to hospitalization might vary with the size of the county, the study attempted to examine the application of section 38(c) in intermediate-sized counties and small, rural counties as well as in Dallas County. Given demographic details of proximate Texas counties, summarized in Appendix A, we selected one intermediate-sized county (Collin County) and one rural county (Hunt County) as representative. Hearings were attended in each of these counties⁵⁴ and interviews were conducted with key personnel, as in Dallas County. The second part of the study involved a comparison of the use of alternatives in these three counties. While this sample of counties was not

49. See notes 5, 6, 8-12 *supra*.

50. *Dixon v. Weinberger*, 405 F. Supp. 974, 976 (D.D.C. 1975); THE PRESIDENT'S COMMISSION ON MENTAL HEALTH, REPORT OF THE TASK PANEL ON LEGAL AND ETHICAL ISSUES 10 (1978); Pokornoy & Frazier, *Texas Surveys Its Mental Hospital Population*, 19 HOSPITAL & COMMUNITY PSYCH. 88 (1968) (over one-half of patients in Texas state hospitals could be more suitably treated elsewhere). See also *Contemporary Studies Project: Facts and Fallacies About Iowa Civil Commitment*, 55 IOWA L. REV. 895, 975 (1970).

51. TEX. REV. CIV. STAT. ANN. art. 5547—36(a) (Vernon Supp. 1980).

52. During the 10-week period, 418 civil commitment proceedings were brought before the court.

53. To encourage candor in the interviews, interviewees were promised that statements would not be attributed to them in the report of the study. Accordingly, specific interviews will not be cited in the description of the study.

54. Permission to attend the hearings was obtained from the judges involved. Fewer hearings occurred in these two counties than was anticipated. Five hearings were held during the 10-week observational period in Hunt County, and three were held in Collin County. Descriptions of each county's mental health system therefore depend mainly on interviews with key personnel as well as a sample of past records of commitment hearings.

designed to be representative of the whole state, it does offer insight into the use of section 38(c) in counties of different sizes and resources.

A third and final part of the investigation involved an assessment of the legal impact of the statutory change. Did the passage of section 38(c) in 1975 make any significant difference in the commitment process? In order to answer this question, we secured judicial permission⁵⁵ to sample and review the mental illness case records of each county court for the three-year period prior to the enactment of section 38(c) (1972-1974).⁵⁶ These data were compared to court dispositions for a post-enactment period (1976-1978). Utilizing aspects of the three methodologies of legal impact studies,⁵⁷ we attempted to trace the effect of the statutory change for each of the three counties.

II. AN OVERVIEW OF THE INVOLUNTARY COMMITMENT PROCESS IN TEXAS

The Texas Mental Health Code authorizes involuntary commitment for both temporary and indefinite hospitalization.⁵⁸ Although there is an additional substantive requirement for indefinite hospitalization not found in

55. Case records are "public records of a private nature"; therefore, they may be "used, inspected, or copied only by a written order" of a judge affiliated with the records. TEX. REV. CIV. STAT. ANN. art. 5547—12a (Vernon Supp. 1980).

56. In Collin County, every third case was sampled beginning with a randomly selected number between one and three. This technique resulted in a sample of 100 cases. In Hunt County, a similar random-start procedure was used, resulting in a sample of 147 cases. In Dallas the total number of cases for each year was computed; an interval was then selected for each year that would yield fifty cases per year for the sample. Once the interval was selected, (e.g., every seventeenth case), a random number between one and seventeen was used to designate the first case. By this method, a sample of 298 cases was drawn from Dallas County.

57. A legal impact study represents an attempt to ascertain how a particular law affects the conduct and attitudes of those individuals, groups or other relevant units located in jurisdictions where that law is in force. By its very nature such a study involves one essential comparison; the comparison between actual behavior patterns in jurisdictions having the law in question and the behavior patterns which would have existed in those same jurisdictions had the law in question never been enacted.

There are three ways in which this comparison can be achieved. One is by comparing the same jurisdiction before and after the passage of the law in question and noting any behavioral changes which seem to have followed as a result of the passage of the law. The second is by comparing jurisdictions which have a particular law with those that do not and assuming that, if not for the law, behavior in the two sets of jurisdictions would have been the same. The third method is by combining the two approaches. This involves examining behavior patterns in a particular set of jurisdictions both before and after they passed the law in question and comparing these patterns with those found over the same period of time in a set of jurisdictions not having the law in question.

Lempert, *Strategies of Research Design in the Legal Impact Study: The Control of Plausible Rival Hypotheses*, 1 LAW & SOC'Y REV. 111, 111-12 (1966).

58. TEX. REV. CIV. STAT. ANN. arts. 5547—31, —40 (Vernon Supp. 1980). For a detailed description of the Code's operation, see M. ROSENTHAL, INTERPRETATION OF THE MENTAL HEALTH CODE (5th ed. 1976), published by the Hogg Foundation for Mental Health.

temporary hospitalization,⁵⁹ the applicable procedures do not vary in any substantial way. As we observed no use of indefinite hospitalization during our study, this overview will focus on temporary hospitalization.

Proceedings for temporary hospitalization are commenced by the filing of an Application for Temporary Hospitalization with the county court of the county in which "the proposed patient resides or is found."⁶⁰ This application must allege that there are no criminal charges pending against the proposed patient, or that proceedings under criminal charges are being held in abeyance due to the incompetence of the proposed patient to stand trial.⁶¹ It must also allege that the proposed patient is mentally ill and requires treatment or observation in a mental hospital to protect the patient or others.⁶² If two Certificates of Medical Examination for Mental Illness are not filed with the application, the court is required to appoint two physicians to examine the proposed patient and submit certificates to the court; no hearing on the application may be held until the two certificates have been filed.⁶³ The certificates must state that both physicians have examined the proposed patient during the past five days and concluded that the proposed patient is "mentally ill and requires observation and/or treatment in a mental hospital."⁶⁴

Although the Code does not require that proposed patients be confined prior to the hearing,⁶⁵ procedures for pre-hearing confinement do exist. A magistrate may issue a mental illness warrant authorizing a twenty-four hour detention of a proposed patient if the magistrate concludes that the proposed patient is mentally ill and is likely to injure himself or others unless immediately restrained.⁶⁶ Thereafter, the court may authorize continued confinement pending the hearing.⁶⁷ The hearing must be held within fourteen days of the filing of the application, and the proposed patient must be served with a copy of the application and notice of the hearing.⁶⁸ If the proposed patient does not have an attorney representing him, the court is required to appoint one for him at the time the application is filed.⁶⁹

59. Indefinite hospitalization requires, in addition to the requirements for temporary hospitalization, that the proposed patient have been the recipient of care in a mental hospital for at least 60 days within the 12 months preceding the institution of proceedings for indefinite hospitalization. TEX. REV. CIV. STAT. ANN. art. 5547—40 (Vernon Supp. 1980).

60. *Id.* art. 5547—31.

61. *Id.* This requirement has its origin in the constitutional provision stating that "the Legislature may provide for the temporary commitment . . . of mentally ill persons not charged with a criminal offense, for a period of time not to exceed ninety (90) days." TEX. CONST. art. I, § 15.

62. TEX. REV. CIV. STAT. ANN. art. 5547—31 (Vernon Supp. 1980).

63. *Id.* art. 5547—32 (Vernon 1958).

64. *Id.* art. 5547—32(a).

65. *Id.* art. 5547—35.

66. *Id.* art. 5547—27(b) (Vernon Supp. 1980).

67. *Id.* art. 5547—27(a).

68. *Id.* art. 5547—33 (Vernon 1958). Notice must also be sent to the proposed patient's guardian or responsible relative, *id.*, but such notice is not a substitute for notice to the proposed patient. *Moss v. State*, 539 S.W.2d 936 (Tex. Civ. App.—Dallas 1976, no writ).

69. TEX. REV. CIV. STAT. ANN. art. 5547—33 (Vernon 1958).

The hearing may be held at any suitable place within the county.⁷⁰ Representation of the state in these proceedings is the obligation of the county attorney or district attorney.⁷¹ Following presentation of the evidence by the state and the proposed patient, the court is required by statute to decide whether the proposed patient is mentally ill and in need of observation and/or treatment for his own welfare and protection or for the protection of others.⁷² The Texas Supreme Court addressed these provisions in *State v. Turner*,⁷³ concluding that a patient confined under the Texas Mental Health Code is "entitled to treatment, to periodic and recurrent review of his mental condition, and to release at such time as he no longer presents a danger to himself or others."⁷⁴ A patient entitled to release from involuntary hospitalization is, by definition, not subject to involuntary hospitalization; thus, this statement by the *Turner* court describes the criteria for initial involuntary hospitalization as well as for release from confinement.

The Code requirement that the proposed patient require observation or treatment must therefore be interpreted in light of *Turner's* affirmative statement that an involuntarily committed patient is entitled to treatment. The committing court must therefore conclude not only that the proposed patient requires treatment, but also that he is likely to receive the treatment he requires if committed. Additionally, *Turner* states that release must occur when the patient is no longer dangerous to himself or others.⁷⁵ If a patient must be released when not dangerous, implicitly he cannot be committed if not dangerous. Thus, the statutory requirement that treatment be necessary for the patient's protection and the protection of others must be interpreted in conjunction with *Turner* to require a finding of danger to self or to others to justify commitment.

Accordingly, before a court in Texas may commit a person it must conclude that the proposed patient is mentally ill, requires treatment for his mental illness, is likely to receive this treatment if committed, and, in the absence of commitment, would pose a danger to himself or to others. Failure to satisfy these criteria requires dismissal of the application. If these criteria are met in a particular case, the court must then decide whether treatment can be accomplished in a setting other than a mental hospital; if so, the alternative form of care may be ordered under the authority of section 38(c).

70. *Id.* art. 5547—36(a) (Vernon Supp. 1980).

71. *Id.* art. 5547—13 (Vernon 1958). Note that there is some confusion whether this provision is still in effect. The Texas Legislature attempted to repeal this provision in 1967, 1967 Tex. Gen. Laws, ch. 680, § 2, at 1785, but the attorney general ruled that the attempted repeal was ineffective. TEX. ATT'Y GEN. OP. NO. M-135 (1967).

72. TEX. REV. CIV. STAT. ANN. art. 5547—38(b) (Vernon 1958).

73. 556 S.W.2d 563 (Tex. 1977).

74. *Id.* at 566. A federal court has also concluded that the Texas Mental Health Code must be interpreted to require a finding of dangerousness as a prerequisite to commitment if it is to survive constitutional scrutiny. *Reynolds v. Sheldon*, 404 F. Supp. 1004, 1009 (N.D. Tex. 1975).

75. 556 S.W.2d at 566.

III. DALLAS COUNTY

Dallas County, Texas, is an urban community inhabited by nearly one and a half million people.⁷⁶ When one of these people experiences serious behavioral problems and does not seek treatment voluntarily, friends and relatives of the person may seek to use the coercive powers of the law to compel the person to accept treatment. In Dallas County this process frequently begins with a visit to Probate Court No. 3, designated as the "mental illness court." After completion of an application for temporary hospitalization,⁷⁷ provided by the court, the person seeking to institute the commitment process is interviewed by one of the members of the court's screening staff whose job it is to determine whether, based upon the information presented by this applicant, the prospective patient is an appropriate candidate for the civil commitment system. In addition to the formal review under the statutory criteria, the mental health screening staff may also discuss alternative approaches to the patient's problems. Following this interview, the screening staff presents the application and staff recommendations to one of the probate judges. Generally, the staff recommendation is followed.⁷⁸ Unless the staff recommends that the proposed patient be screened out of the commitment process, the judge usually signs a mental illness warrant directing the sheriff to take the proposed patient into custody and deliver him to Parkland Hospital for examination by the emergency room psychiatric staff.

Parkland Hospital is a public hospital operating under the authority of the Dallas County Commissioners. The hospital has eighteen psychiatric beds that are primarily used for volunteer teaching-case patients under the care of members of the Southwestern Medical School Psychiatry Department. The psychiatric emergency room staff consists of three social workers from Dallas County Mental Health Mental Retardation Center and the psychiatric staff from the hospital.

Prospective patients may arrive in the Parkland Hospital emergency room psychiatric section other than by means of a mental illness warrant. Lacking knowledge of the formal application process or the time to utilize it, the patient's family or friends or law enforcement authorities may bring the proposed patient to Parkland Hospital for assistance with the patient's behavior. A person may also seek assistance for his own behavioral or medical problems. The Texas Mental Health Code does not permit the involuntary detention of a proposed patient absent a mental illness warrant, however.⁷⁹ Accordingly, if the psychiatric staff of the hospital concludes that discharge of a particular patient would pose a serious risk to the patient or the community and the patient does not concur, and no mental illness warrant has yet been issued, the staff is often in the tenuous

76. In 1976 Dallas County's population was estimated to be 1,449,496. One percent of the county's population lives in rural areas. *See* Appendix A.

77. TEX. REV. CIV. STAT. ANN. art. 5547—31 (Vernon Supp. 1980).

78. One of the judges explained that when he suspects ulterior motives of the family the staff recommendation for continued processing of the case may not be followed.

79. TEX. REV. CIV. STAT. ANN. art. 5547—28 (Vernon Supp. 1980).

position of trying to keep the patient in the hospital while the patient's friends or relatives proceed downtown to begin the formal application to the mental illness court. Sometimes the application is completed in time; other times frustrated staff must watch a dangerously disturbed individual walk out of the hospital.⁸⁰

When the patient has been brought to the hospital under the authority of a mental illness warrant, or one is obtained in a timely fashion, the emergency room staff views initial screening for alternatives to commitment as one of its goals. If, in the opinion of the emergency room staff, alternative treatment is not feasible and an initial examination of the patient supports the conclusion that the statutory criteria for hospitalization are satisfied, the patient is sent to the Medical Diagnostic Center at the Hillside Center.⁸¹

The Hillside Center, previously the Beverly Hills Hospital, was leased by Dallas County Mental Health Mental Retardation Center in January 1978 for adult in-patient mental health services. Dallas County Mental Health Mental Retardation Center has contracted with Dallas County to operate a sixty-bed Medical Diagnostic Center at Hillside; this center conducts the diagnostic activities in the commitment proceedings. The diagnostic activities of the center consist of a multidisciplinary approach that combines the input of social workers, psychologists, and psychiatrists. The social workers are expected to contact the family and examine the facts underlying commitment. This investigation must be completed prior to the staff meetings that are held on the Monday and Wednesday preceding the Tuesday and Thursday commitment hearings. Because of the desire to maximize the use of the Medical Diagnostic Center beds, patients arriving between Tuesday and Friday will be discussed at the staff meetings on Monday; patients arriving between Saturday and Monday will be discussed on Wednesday.

The responsibility to investigate alternatives typically falls upon the social workers because of their knowledge of the alternatives. Time pressures to prepare for the staff meetings and subsequent hearings, along with caseload demands, however, may make it difficult for the social workers to engage in a complete investigation of alternatives.

The psychological staff administers standard psychological tests⁸² and

80. For a discussion of a similar problem in another state and a proposed solution, see Shuman, Hegland & Wexler, *Arizona's Mental Health Services Act: An Overview and an Analysis of Proposed Amendments*, 19 ARIZ. L. REV. 313, 327 (1977).

81. For a variety of reasons, largely budgetary, the number of fully staffed beds available at the Medical Diagnostic Center fluctuated during the period of our observation. The number of patients determined by Parkland to need further observation at the Medical Diagnostic Center fluctuated in harmony with the center's bed availability. Parkland's floating standards would appear to be an example of Roemer's Law that health care services utilization increases as a function of availability and not necessarily of need.

82. During the second quarter of 1979, for example, 69% of all patients admitted to the Medical Diagnostic Center received standard psychological tests. "The remainder were insufficiently stable to receive standard testing." Report on Operations of Medical Diagnostic Center, April 1, 1979 to June 30, 1979 (unpublished report by Dallas County Mental Health & Mental Retardation Center, Dallas, Texas).

the psychiatric staff conducts mental status examinations. These different perspectives are combined at the staff meetings that occur on the day preceding the hearing. At the meeting each discipline provides a short statement of its findings and recommendations, if any. Although all participants are permitted to question the others, regardless of rank, we observed no rigorous exploration of alternatives in the staff meetings. Instead, for example, when one social worker stated that alternative *A* was not feasible, no one probed the basis for that conclusion or asked about alternatives *B*, *C*, *D*, or *E*. The staff meetings result in a consensus recommendation; that recommendation may be that the patient be committed to Terrell State Hospital, that the patient be discharged and the case dismissed, or that some alternative to state hospitalization be utilized. This recommendation becomes the position of the state at the hearing.

Presentation of the state's case at the hearing falls upon a member of the Dallas County District Attorney's staff, who is assigned this duty as a part-time responsibility as a member of the civil section of that office. The prosecutor plays no role in the staff meetings or recommendations. Typically, the prosecutor reviews the Medical Diagnostic Center reports and recommendations on file the afternoon before the hearing and then presents the state's case at the hearing. In those instances when the Center has recommended dismissal, the prosecutor will generally move that the court dismiss the case. When dismissal has not been recommended and the parties have not reached agreement, the prosecutor is called upon to present the state's case. This generally involves a litany of questions directed to the state's psychiatrist in which he is asked for his diagnosis, recommendation, and prognosis. Occasionally, the prosecutor may also question the party who filed the application for hospitalization.

The attorneys representing the patients are, with rare exception, appointed by the court. An attorney wishing to receive these appointments contacts the mental illness court and is placed on the rotation roster. When the attorney's name comes up in the rotation, usually two or three times a year, he is assigned one-half the Tuesday/Thursday docket for a particular week. This assignment may entail between twenty and thirty cases for the week. The compensation to the attorney for his services is a flat twenty-five dollars per case.⁸³

The typical court-appointed attorney⁸⁴ in this process is a young male in a solo or small practice who handles commitment cases to help pay the rent as his practice gets started. Although some of the attorneys specialize in one area of the law, such as criminal or probate, the majority have a general practice and lack expertise in mental health law or psychiatry. The majority had not taken psychology or sociology courses, and those who

83. Twenty-five dollars per case is the lowest amount of reimbursement permitted by the Code; no maximum amount is specified. TEX. REV. CIV. STAT. ANN. art. 5547—15 (Vernon Supp. 1980).

84. This composite of court-appointed attorneys is based upon our observations and interviews with eight of the appointed attorneys. These attorneys represent 40% of the court-appointed attorneys during our observation period.

had, had taken only one or two basic courses as undergraduate students. None had taken a law-and-psychiatry or law-and-psychology course in law school. None had attended continuing legal education courses on mental health law. And, most surprisingly, one-half of the attorneys interviewed were not even aware of the existence of the Hogg Foundation's *Interpretation of the Mental Health Code*⁸⁵ or Professor Dix's *Texas Mental Health Commitments*,⁸⁶ both of which are keyed to Texas mental health law.

The appointed attorney's hearing preparation typically began on Monday for the Tuesday hearings and on Wednesday for the Thursday hearings. The pre-hearing activities usually entailed a review of the file at the court and a trip to the Medical Diagnostic Center to speak with the patient.⁸⁷ Only one attorney indicated that he conducted an independent investigation beyond the file review and patient interview.

The failure of these attorneys to prepare thoroughly for these hearings⁸⁸ is a function of a number of factors. The notice given the attorney of the Tuesday/Thursday hearings simply does not permit the attorney the time to engage in his own investigation of evidence or alternative treatments. Not until the day before the hearing is the attorney informed which cases will proceed to hearing. Although the attorney may request a continuance, he should first secure the approval of his client, who may not consent. More significantly, the system is designed to provide little incentive for the attorney to seek a continuance or to engage in a more thorough investigation. Reimbursement of a flat twenty-five dollars per case suggests that

85. M. ROSENTHAL, *supra* note 58.

86. G. DIX, *TEXAS MENTAL HEALTH COMMITMENTS* (1978).

87. This attorney-client contact occurred under less than ideal circumstances. The attorneys were generally not provided a private interviewing area. Thus, in order to communicate effectively with their client in a corner of the ward, they had to contend with their client's behavioral problems as well as with the remaining patients in the ward, who frequently interjected themselves into the attorney's communications with his client.

88. One suggested list of activities for the proposed patient's attorney provides as follows:

Effective representation requires at least the following activities on the part of counsel. The attorney should make a thorough study of the facts of the case, which should include court records, hospital records, and information available from social agencies. Communication with the patient is, in the ordinary case, a must. Where such communication is impossible for medical reasons, the family and friends of the patient should be contacted to ascertain the true facts behind the petition. It is essential that the attorney have a full understanding of the events preceding the filing of the petition. An investigation of the financial condition of the patient and his family—including hospitalization insurance—is necessary to determine if certain alternatives to hospitalization should be explored. Finally, the attorney should explore the treatment and custodial resources of the community. He should understand the various services offered by social agencies and the avenues by which these resources can be applied to meet the needs of his client as alternatives to involuntary commitment.

The attorney has a responsibility to consult with the examining physicians concerning the medical history of the patient, the diagnosis, the proposed treatment and the prognosis.

Wexler & Scoville, *supra* note 16, at 56 (footnotes omitted). See also Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*, 44 TEXAS L. REV. 425, 450 (1966).

these appointments can be economically justified only if the attorney can keep his time expenditure to a minimum. Many attorneys perceive another incentive to limit their investigation and resulting in-court presentation: the majority of attorneys interviewed were of the opinion that the judges were not interested in overly aggressive, time consuming representation. Some attorneys thought that an overly aggressive attorney might not be reappointed; they therefore tempered their investigation and presentation accordingly. Although both judges who heard cases over the summer stated in interviews that they expected defense attorneys to take whatever action was necessary to protect the rights of their clients, many of these attorneys interviewed received a different message.

A. *Noncontested Hearings*

The mental illness court docket in Dallas consists of contested and non-contested cases. The noncontested cases are handled summarily and are designed for those instances when the proposed patient does not wish to contest the staff recommendations. No evidence is presented in these cases and the patient is ordinarily not present; his attorney generally represents the patient's desires to the court. Because the noncontested proceedings take less time than the contested proceedings,⁸⁹ there is a financial incentive for the attorney to induce his client to enter a no-contest plea.⁹⁰ Although we discovered no evidence that attorneys misrepresented the patient's desires, it is known that the manner in which a question is asked will affect the answer.⁹¹ Thus, the attorney's phrasing of questions—Do you want help? What do you want to do? They want to send you to the nuthouse; do you want to go there?—combined with the financial expediency of noncontested proceedings holds the potential for abuse.

Another potential abuse exists if the attorney is permitted to enter a no-contest plea without the proposed patient's approval. In some cases the attorney stated that although the proposed patient did not expressly concur in the staff recommendations, the attorney concluded that the proposed patient was so disoriented that treatment would be in his best interest and the attorney therefore entered a no-contest plea. This procedure is troubling on several grounds. The Mental Health Code does not authorize the

89. Contested cases had a median time of 14 minutes compared to one minute for non-contested cases.

90. This incentive for no-contest pleas has been noted in other studies. For example, "[ad litem] were paid a flat fee for each case. That is, their rate of pay depended on the rapidity with which they could finish." T. SCHEFF, *BEING MENTALLY ILL: A SOCIOLOGICAL THEORY* 137 (1966).

No attorneys we observed or interviewed moved to dismiss the proceedings when his client stated that he would voluntarily go to the state hospital. There is evidence that hospital staff perception and response to voluntary patients is better than their perception and response to committed patients. Denzin & Spitzer, *Patient Entry Patterns in Varied Psychiatric Settings*, 50 *MENTAL HYGIENE* 257, 261 (1966). Thus, when an attorney's client indicates a willingness to volunteer, albeit coerced, the attorney should consider an attempt to dismiss in exchange for voluntary hospitalization.

91. See Loftus & Zanni, *Eyewitness Testimony: The Influence of the Wording of a Question*, 5 *BULL. OF PSYCHONOMIC SOC'Y* 8 (1975).

attorney to enter a no-contest plea in the absence of his client's consent. To the contrary, it has long been recognized in Texas that a guardian or attorney ad litem may not waive his client's substantial rights.⁹² The United States Supreme Court has ruled that an adult facing civil commitment is entitled, as a matter of constitutional law, to an adversary hearing to determine the propriety of commitment. At such a hearing the state must prove its case by clear and convincing evidence.⁹³ The right to this adversary hearing is thus a substantial right. Therefore, under existing Texas doctrine, the guardian or attorney ad litem is not permitted to waive his client's right to a civil commitment hearing in the absence of the requisite waiver by his client.

To waive a constitutional right the United States Supreme Court has required a voluntary and intelligent relinquishment of a known right.⁹⁴ Thus, in civil commitment proceedings, "[i]n the absence of a voluntary, knowing and intelligent waiver, adults facing commitment to mental institutions are entitled to full and fair adversarial hearing in which the necessity of their commitment is established"⁹⁵ If the proposed patient is so disoriented that he lacks the capacity to waive these rights, the constitution requires a hearing.⁹⁶ If the patient is not disoriented and does not concur with staff recommendations, then a hearing is particularly appropriate and a "best interest waiver" by the attorney raises serious ethical and legal questions. The legislature has determined that the judge, and not the defense attorney, is to decide the outcome of civil commitment proceedings. The "best interest waiver" effectively shifts that decision to the attorney, leaving the judge, in a case where the patient has not indicated a desire to enter a no-contest plea, to rubber stamp the attorney's decision to commit his client.

92. *Reasoner v. State*, 463 S.W.2d 55, 59 (Tex. Civ. App.—Houston [14th Dist.] 1971, writ ref'd n.r.e.). See also *Lowery v. Berry*, 269 S.W.2d 795, 797 (Tex. 1954). Although courts in other jurisdictions have permitted a guardian ad litem to waive rights, such as the attorney-client privilege, of his "incompetent," authority to waive in those instances was premised upon the guardian ad litem's protection of the interests of the "incompetent" he was appointed to represent or defend. Thus, in *Lietz v. Primock*, 84 Ariz. 273, 327 P.2d 288 (1958), a guardian ad litem appointed by the court to prosecute a fraud claim against the incompetent's former attorney was permitted to waive the attorney-client privilege so that the guardian ad litem could depose the defendant in the pursuit of his case. See also *Yancy v. Erman*, 99 N.E.2d 525 (Ohio C.P. 1951). Since the guardian ad litem in civil commitment proceedings is appointed to defend the patient, however, a waiver of this defense is wholly contrary to these interests. Therefore, implied authority to waive should not be found in this context.

93. *Addington v. Texas*, 99 S. Ct. 1804, 60 L. Ed. 2d 323 (1979).

94. *Johnson v. Zerbst*, 304 U.S. 458, 464 (1938).

95. *Parham v. J.R.*, 99 S. Ct. 2493, 2516, 61 L. Ed. 2d 101, 134 (1979) (Brennan, J., concurring in part and dissenting in part).

96. Occasionally, the patient's attorney indicated at a hearing that the hearing should be waived and his client committed because the client was not competent to stand trial in the commitment proceedings. In the context of criminal law, which recognizes the concept of incompetency to stand trial, a criminal proceeding may be held in abeyance until the defendant is competent and can participate adequately in his defense. The civil commitment proceedings are not held in abeyance, but rather, because of a concern that the patient could not participate adequately in his defense, the defense is waived by the lawyer.

Another facet of the noncontested docket is that it is here where the use of alternatives to state hospitalization under section 38(c) is revealed. The Medical Diagnostic Center staff has taken the position that patient cooperation and willingness to seek treatment are prerequisites to nonhospital care and must be manifested prior to the hearing. Thus, a patient who maintains at the hearing that he is not committable but that if he is committed, he would prefer treatment in the community, will not be recommended for a community alternative. There is no statutory requirement that the patient's option be exercised prior to a finding of committability. The staff, however, apparently wishes to parcel out its precious alternative resources only to the most cooperative of patients.

Perhaps the staff believe that the most cooperative patients are most likely to benefit from alternative treatment. Nonetheless, there is a serious constitutional question raised by this forced option. The Supreme Court has recognized that one may not be required to forego one constitutional right as the cost of asserting another.⁹⁷ If the right to a hearing and the right to commitment to the least restrictive alternative are both constitutionally protected,⁹⁸ a proposed patient may not be forced to waive the right to the least drastic alternative form of treatment in order to assert the right to an adversary hearing. Requiring the patient to exercise his option before the hearing is, therefore, a constitutionally flawed procedure. Although patient cooperation is a legitimate consideration in treatment options,⁹⁹ there is no cogent reason for concluding that every proposed patient who wishes to question his committability at hearing will fail to cooperate in a particular treatment program if committed. Even so-called "voluntary" treatment entails an element of coercion.¹⁰⁰ This coercion may result from personal discomfort with one's own behavior or the threat of a divorce, job loss, or revocation of a professional license. The threat of state hospitalization is simply another form of coercion. Therefore, rather than excluding a prospective patient from a treatment program because his participation in that program may have been coerced, the decision to accept the patient in a particular program should be made on a case-by-case basis, considering factors such as the patient's condition, his response to particular treatment options, the degree of structure involved in a particular option, and the likelihood of family support.

B. *Contested Hearings*

When the patient disagrees with the staff recommendation and no "best

97. *Simmons v. United States*, 390 U.S. 377 (1968). In *Simmons* the defendant's assertion of a search and seizure as a fourth amendment violation required that he admit a possessory interest in the seized evidence. *Id.* at 390. The government subsequently attempted to introduce this testimony at trial over the defendant's assertion of his fifth amendment privilege against self-incrimination. The Court found it "intolerable that one constitutional right should have to be surrendered in order to assert another." *Id.* at 394.

98. See notes 13-27 *supra* and accompanying text.

99. See Hoffman & Foust, *supra* note 16, at 1115.

100. S. HULLECK, *PSYCHIATRY AND THE DILEMMAS OF CRIME* 314 (1967).

interest waiver" is entered by the patient's attorney, a contested hearing is conducted. These proceedings typically involve the state's calling the psychiatrist and proceeding through the standard litany of questions. Asking the psychiatrist for his recommendation frequently evoked a statement that alternatives to confinement were not feasible.¹⁰¹ If the psychiatrist's recommendation did not state that alternatives were infeasible, the prosecutor frequently asked a specific question about the possibility of alternative treatment.

Following the direct examination, the patient's attorney conducted cross-examination of the psychiatrist and often called the patient, who was examined by his attorney and cross-examined by the prosecutor. Occasionally, the applicant was called by the state or the patient. No other witnesses typically were involved. The failure of the patient's attorney to call other witnesses is a function of the factors discussed earlier.¹⁰² The short notice of hearing provided does not permit factual investigation and the issuance of subpoenas for witnesses favorable to the patient. Moreover, no incentive is perceived for this more aggressive representation. It is thus not surprising that few, if any, attorneys observed utilized a pure legal method in their representation. The majority of attorneys proceeded instead on a modified medical model or "best interest" approach,¹⁰³ filtering the patient's expressed desires through the psychiatrist's opinion of the patient's needs, or in some instances, modifying this by their own evaluation of the patient's needs. In numerous instances throughout the study the patient's attorney actually assisted the prosecutor in committing the patient by eliciting evidence that supported the commitment the attorney's client contested.

Even when the psychiatrist's conclusions were inconsistent with or contrary to other evidence presented, few defense attorneys probed this inconsistency on cross-examination or questioned the basis for the psychiatrist's unexplained conclusions. The more aggressive attorneys were more likely to reveal that the psychiatrist had utilized insufficient or incorrect information in reaching his conclusions. In these cases, the judge ordered a continuance so that a more accurate and complete factual basis for a decision

101. In all cases that proceeded to hearing, the state psychiatrist recommended hospitalization. In 10% of these cases, however, the psychiatrist revealed that state hospitalization would not be necessary if a particular alternative was available. In 41% of the cases that proceeded to hearing, the use of alternatives was never raised during the course of the hearing.

102. See text following note 88 *supra*.

103. Advocates of the medical model contend that the appropriateness of involuntary hospitalization is a medical question that should be decided by physicians. See, e.g., Parham v. J.R., 99 S. Ct. 2493, 61 L. Ed. 2d 101 (1979); Davidson, *Mental Hospitals and the Civil Liberties Dilemma*, 51 MENT. HYGIENE 321 (1967). Although this approach has been rejected for involuntary hospitalization of adults, Addington v. Texas, 99 S. Ct. 1804, 60 L. Ed. 2d 323 (1979), in practice a modified medical approach has frequently been substituted for the pure legal method of deciding disputes. In this modified medical model the judge and lawyers assume that the best interests of the prospective patient will be served if the physician's recommendation, and not the patient's expressed desire, is followed. See Hilday, *Reformed Commitment Procedures: An Empirical Study in the Courtroom*, 11 LAW & SOC. REV. 651 (1977).

could be obtained. In many of these instances alternative forms of care were subsequently agreed upon where none had been thought possible before.

The overall tenor of the patient representation was manifested in the fact that no commitment order during the study was appealed although numerous patients vigorously protested their commitment, nor was any post-commitment attorney-patient contact disclosed by any attorney. In no instance did an attorney indicate any attempt to ascertain whether the treatment promised at hearing was actually provided his client at the hospital, whether release had become appropriate, or whether an alternative treatment had been successful.

The state's chief witness in the commitment proceedings was a psychiatrist employed by the Medical Diagnostic Center. To prepare for these hearings the psychiatrist conducted a mental status examination¹⁰⁴ of the patient and participated in the staff meetings at the Center. At these meetings, based upon inter-disciplinary input, the staff recommendation emerges that the psychiatrist will proffer at the commitment hearing. Unfortunately, the presentation at the hearing rarely involves a detailed description of the specific treatment needs of the patient, or the specific treatments available at the state hospital or local in-patient and out-patient facilities. Further, defense counsel rarely elicits this information on cross-examination.¹⁰⁵ Information about alternative treatments is extremely important, for Texas law requires that the judge decide whether the patient requires treatment for a mental illness and, if so, where that treatment should be administered.¹⁰⁶ If the judge rather than the psychiatrist is to decide the outcome of the proceedings, then the judge must be provided with information on the specific treatment needs of the patient and the specific treatment capabilities of all potential facilities and programs. Thus, in theory, the judge may expect the state to exclude alternatives to state hospitalization as an element of its burden of persuasion; in practice, however, the burden is easily satisfied.

None of the patient's lawyers in the cases observed called a mental health professional not employed by the state to testify that alternatives were feasible in a given case. In some instances, however, the judge desired additional professional input and therefore continued the hearing and entered an order of protective custody¹⁰⁷ directing that the patient be confined in the state hospital for up to fourteen days and that the state hospital render a diagnostic report on the patient within that time. The advantage of this use of the order of protective custody is that the court obtains additional information on commitment issues without losing its authority over the patient.

104. Gottlieb, *Mental Status Examination*, 9 AM. FAM. PHYS. 109 (1974).

105. In only 34% of the contested cases did the defense attorney inquire about alternatives to hospitalization. Others raised the issue in an additional 15% of the cases.

106. TEX. REV. CIV. STAT. ANN. art. 5547—38(c) (Vernon Supp. 1980). See notes 72-74 *supra* and accompanying text.

107. TEX. REV. CIV. STAT. ANN. arts. 5547—66, —67 (Vernon 1958 & Supp. 1980).

If the judge concludes that the state has already established a *prima facie* case and that a commitment order would therefore be entered if an immediate decision were necessary, the protective custody procedure resembles a short-term commitment for fourteen rather than ninety days, with the additional requirement that the state hospital report back to the court. The problem inherent in this approach occurs when the state has not yet established a *prima facie* case for commitment and the patient does not consent to the order of protective custody. Arguably, using the order in these circumstances is the equivalent of a two-week commitment not supported by the evidence. Because the state already detained the patient for up to six days for examination prior to hearing it may be argued that the state must now prove its case or suffer a dismissal.

Although compelling legal arguments can be advanced against this use of the order of protective custody, its use is interesting as an attempt to utilize to the maximum the resources that the system has to offer. This effort typifies the active role that the judiciary plays in commitment proceedings in Dallas. One judge has even conducted unannounced site visits to the Medical Diagnostic Center; these visits resulted in the identification of a variety of problems in the center and in its immediately addressing these problems. On another occasion, that same judge subpoenaed a Parkland Hospital administrator whose actions in a particular case allegedly contributed to confusion and frustration in the mental health system. In sum, the judiciary has played an active and creative role in the Dallas mental health system. While a centralized office to coordinate the many components of the mental health system in Dallas may be desirable, in its absence the judiciary has filled the void.

IV. COLLIN COUNTY

Collin County was selected to represent an intermediate-sized county because of its population of 100,000, forty-percent of which is rural.¹⁰⁸ The situation in Collin County thus illustrates a number of problems of mental health care in nonurban settings.¹⁰⁹

Concern for mental illness cases appears to be of low priority, and the system that deals with such cases is born more out of reaction to external crises rather than rational, planned action. The result is a patchwork system. Part of the problem is that there are not enough mental illness cases being processed through the civil commitment machinery to sustain a viable operation.

There are two different paths to civil commitment for cases arising in Collin County. The first involves most nonemergency cases. Applications brought to the court are referred to a mental health worker who serves as a

108. See Appendix A.

109. Only three hearings were held in this county during our summer observation period. The conclusions in this study are therefore based largely upon information from interviews with the personnel in the system and on the 100 cases sampled from files of commitment hearings held between 1974 and 1978.

screening agent. Cases not screened out at this level are sent to the judge, who may then execute a mental illness warrant. The proposed patient is then examined by two physicians and a date is set for a hearing in the county.

The second procedure, initiated in 1977, is used in emergency cases. This procedure, operating in the majority of cases, evolved when the community lost its short-term observation facilities for psychiatric cases. Prior to 1977, proposed patients were detained locally in the county jail. An amendment to section 27 of the Mental Health Code precluded the use of jails for this purpose unless they were "specifically equipped and staffed to provide psychiatric care and treatment."¹¹⁰ Following this amendment an attempt was made to utilize the Collin Memorial Hospital for pre-hearing detention. The hospital vehemently objected, however, contending that its existing facility lacked the requisite security for acutely disturbed psychiatric patients and its staff lacked training in the care of such patients.

In an attempt to resolve the ensuing controversy the following procedure was instituted: A person wishing to institute civil commitment proceedings signs a Statement of Conduct and/or Circumstances, which is presented to a magistrate who may then issue a warrant for medical examination. If a warrant is issued, the patient is then seized and taken by the sheriff to Collin Memorial Hospital, where a physician examines the patient. If the physician concludes that the proposed patient is mentally ill, requires mental hospitalization, and is likely to cause injury if not restrained, the sheriff takes the patient to the Wichita Falls State Hospital, with a request for emergency admission.¹¹¹ All subsequent proceedings in the case occur in Wichita Falls. The judge who hears the case, the lawyers who prosecute and defend, and the physicians who provide information to the court all reside in Wichita Falls, which then bills Collin County for these services.

Not all in Collin County have found this compromise procedure a panacea. First, it is alleged, the statutory definition of emergency is often strained to avoid keeping patients in Collin County who could be cared for in the Collin Memorial Hospital.¹¹² Secondly, the Mental Health Code provides that applications for temporary hospitalization "may be filed in the county court of the county in which the proposed patient resides or is found."¹¹³ The hearing on this application is to be held "within the county."¹¹⁴ Compliance with the Code's procedures are obligatory if a

110. 1977 Tex. Gen. Laws, ch. 402, § 1, at 1093 (codified at TEX. REV. CIV. STAT. ANN. art. 5547—27(a) (Vernon Supp. 1980)).

111. TEX. REV. CIV. STAT. ANN. art. 5547—28 (Vernon Supp. 1980).

112. An emergency exists when the proposed patient "has symptoms of mental illness and is likely to cause injury to himself or others if not immediately restrained." *Id.* art. 5547—28(b).

113. *Id.* art. 5547—31. Although the language "may be filed" is permissive rather than mandatory, the subsequent listing of acceptable places in which applications may be filed demands an interpretation that an application may be filed in a listed place only, and nowhere else.

114. *Id.* art. 5547—36(a).

commitment is to be valid.¹¹⁵ When, as is typically the case, the patient is a Collin County resident who was in Collin County at the institution of the proceedings, the Mental Health Code does not permit a hearing outside the county. Moreover, even if it is within the power of the patient to waive this requirement, it is inconceivable that in all cases the patient is possessed of the requisite capacity to execute a valid waiver and chooses to do so.¹¹⁶

This procedure has other faults. Removal of the commitment proceedings from the community not only places major logistical hurdles in the path of an effective defense by the patient, but it also effectively destroys the incentive to utilize Collin County community alternatives. People in Wichita Falls are not likely to be knowledgeable of the alternatives in Collin County. Moreover, at the time of hearing the patient has already been removed from the community. Thus, much of the incentive to keep him in the community has vanished by the time of the hearing. Finally, the emergency procedure bypassed the mental health screening worker, who often was not informed of the case. In short, the emergency transfer operation in Collin County resembled banishment of local citizens to another county system.¹¹⁷ The mental health worker in Collin County resigned during the period of our observations, partially because of her frustration with this system. As of this writing we are not aware of her replacement by another mental health professional.

There were also problems with the nonemergency system. When the applicant satisfied the judge that a commitment might be appropriate, two local physicians were appointed to examine the proposed patient. Although two psychiatrists maintain a practice in McKinney, the county seat, these individuals were reluctant to participate in the commitment process. Thus, in many instances, psychiatric input into the commitment proceedings is limited or nonexistent.

If the proposed patient is indigent, counsel is appointed by the court and reimbursed at the rate of \$75 per case. Counsel is usually provided two days' notice of the proceedings, one day longer than in Dallas, and counsel interviewed in this study perceived no judicially imposed limitation on their zealotry. Unfortunately, however, the appointed attorneys lacked any substantial training in psychology, psychiatry, or sociology, had not taken law school or continuing education mental health law courses, and appeared unaware of relevant publications keyed to Texas mental health law. Our discussions and observations suggested that hearing preparation rarely entailed more than talking with the patient. In no hearing observed or discussed did the attorney independently investigate or examine witnesses on the subject of less drastic alternatives to hospitalization.

115. *Florence v. Crawford*, 351 S.W.2d 77 (Tex. Civ. App.—Texarkana 1961, no writ).

116. For a discussion of a guardian ad litem's authority to waive rights of his ward, see note 92 *supra*.

117. The mental health screening worker who is charged with keeping records of all commitments stated that the county did not receive a record of the outcome of the initial proceedings or of the later 90-day commitment hearing at the Wichita Falls Hospital.

The failure of defense attorneys to examine witnesses about alternatives is partially explained by the fact that physicians were not present in any of the hearings observed. Instead, without a hearsay objection by the patient's attorney, the physician's conclusory affidavit was received into evidence.¹¹⁸ Physicians, especially psychiatrists, are so reluctant to testify that many refuse to even examine the patient if they will later be required to testify. The psychiatrists point out that testifying in court requires them to cancel appointments. Given the unique problems of private psychiatric patients, an appointment cancellation may, according to the doctors, result in the patient's terminating the relationship; these psychiatrists conclude that such a result is an unacceptable cost of testifying.

The consequence of the physician's absence from the hearing is that his diagnosis and conclusion cannot be effectively questioned and no inquiry into his consideration of less drastic alternatives can occur. Unless the physician tells the court what treatment the patient requires, whether the patient is dangerous and, if so, in what specific way, what alternative forms of care have been considered and why they have been rejected, the hearing is empty formalism. This empty formalism does not meet the requirements of the Mental Health Code. When the psychiatrist's conclusions are not "supported by statements of the behavior on which they are based, the court does not have sufficient information to make a proper legal determination of whether the potential harm is great enough to justify depriving the person of his liberty."¹¹⁹ The factual data supporting the psychiatrist's opinions must be shown by the evidence, or the decision to commit will be the physician's, and not the court's as prescribed by the legislature.¹²⁰

One of the dangers of this empty formalism was illustrated graphically in a hearing we observed. A patient diagnosed as psychotic depressive with alcohol addiction had attempted suicide through an overdose of prescribed medication. The patient was then treated for the overdose at Collin Memorial Hospital. At the subsequent hearing the patient was present and permitted to roam the court house unattended while another case on the docket was heard. When his case was called, no live medical or psychiatric testimony was received. Based upon the physician's conclusory affidavits, the court committed the patient to the state hospital.

Following the hearing we interviewed the director of the Collin County Mental Health Clinic, an extension of the Wichita Falls State Hospital and part of the Texas Department of Mental Health and Mental Retardation. During the interview, in order to ascertain the type of patients appropriate for the out-patient care provided at the clinic, we described as a hypothetical the case of the committed patient whose hearing we had previously observed. We were told that out-patient care at the clinic would have been appropriate for this hypothetical patient. The physician's ex parte affidavit

118. For a discussion of the evidentiary and constitutional aspects of this procedure, see Shuman, *The Road to Bedlam: Evidentiary Guideposts in Civil Commitment Proceedings*, 55 NOTRE DAME LAW. 53 (1979).

119. *Moss v. State*, 539 S.W.2d 936, 950 (Tex. Civ. App.—Dallas 1976, no writ).

120. *Id.*

admitted into evidence at the hearing did not explain whether this alternative form of care had been considered and, if so, why it had been rejected. Moreover, neither the court nor counsel raised the issue of local alternatives. In essence, the hearing was a mere formality. No careful independent inquiry by the court occurred; instead, the physician's untested decision was rubber-stamped by the court.

In sum, the Collin County system of civil commitment is disorganized; local support facilities such as the community mental health clinic are largely isolated and underutilized. The judicial procedures observed did not evidence the exploration of less drastic alternative forms of treatment. Instead, the county relied heavily on the Wichita Falls State Hospital, located a considerable distance from the county. Moreover, cases were often returned to Collin County by Wichita Falls State Hospital, with little or no follow up by the Collin County system. Although there were few local alternative forms of treatment, the existing alternatives were often unrecognized and seldom used to their full potential. Therefore, residents of Collin County experiencing mental health problems were not likely to remain in their community.

V. HUNT COUNTY

Hunt County is a largely rural county located in the geographic area served by the Terrell State Hospital.¹²¹ Its population of 50,000 is served by mental health facilities located in Greenville, Texas, about seventy miles northeast of Dallas.¹²²

An informal system of handling civil commitment cases has developed in Hunt County, partially because of its size. The county judge is apparently the central figure in the initiation of court action, although a case occasionally originated at the local community center mental health facilities. These facilities include a Terrell State Hospital Outreach Center with a staff of psychologists, social workers, and a psychiatrist from Terrell State Hospital who visited the county two afternoons a week. A second facility, housed in the same building, was a mental health and mental retardation community mental health center. The outreach center handled problems referred to them by citizens during the day, and the mental health and mental retardation facility covered evenings and weekends.

Perhaps one reason the judge was a central figure was that, according to those interviewed, the local prosecutor disliked handling civil commitment cases. The local prosecutor actively discouraged initiation of these cases and avoided involvement in cases that had been filed. In fact, no one from the prosecutor's staff was at any of the five hearings held during our observations, and it appears that this is the norm rather than the exception.

121. See Appendix A.

122. Five commitment hearings occurred in this county during our ten-week study period. Thus, the description of the mental health system and conclusions about the commitment process are based largely on interviews with key personnel and on observing trends in commitment cases sampled from a six-year period, 1973 to 1978. See note 56 *supra*.

Hampered by the lack of a county in-patient psychiatric facility, Hunt County, like Collin County, relied upon the state hospital system. The judge often sent patients on an order of protective custody to Terrell State Hospital, thirty miles away in Kaufman County, for evaluation. The procedure differed from Collin County's, however, in that these cases were returned to the county for hearings on ninety-day commitments.¹²³ This procedure of using an order of protective custody for examination was partly in response to a lack of facilities at the local hospital, and partly in response to a lack of local physicians willing to participate in the commitment process. When medical examinations were performed locally, physicians often refused to testify later at the hearings, and their affidavits were simply accepted into the record. There were no psychiatrists residing in the county, and most of the physicians used were osteopathic, not allopathic physicians. Although one part-time staff member of the outreach center was a psychiatrist, he was not used for diagnostic purposes in the commitment proceedings. Moreover, one physician mentioned in an interview that the second physician often made a diagnosis based on the record and the diagnosis of the first physician rather than examining the patient himself.¹²⁴

The civil commitment hearings were simply paper signing ceremonies rather than independent judicial determinations of the propriety of commitment. The patient was not present at any of the five hearings observed; in each case the applicant and the appointed attorney met in the judge's chambers for the hearing, which averaged ten minutes. In none of the five hearings was any alternative raised; the attorney appointed by the court assumed that hospitalization was best and that local options were not feasible. Little prehearing investigation occurred. In one hearing observed it appeared that the patient's appointed attorney had done no pre-hearing preparation and actually became familiar with the facts of the case during the hearing. It further appeared that the attorneys lacked expertise in mental health law as they apparently had not taken traditional courses or utilized available materials for self-study.

In Hunt County, unlike Collin County, there was a close working relationship between the judge and the community mental health facilities. The judge occasionally referred cases to the center for intervention. These referrals were done informally, rather than as section 38(c) commitments. Conversely, some cases coming to the center were referred to the court when local treatment options seemed inappropriate. This informal relationship between the court and the center was strengthened by the close ties between Terrell State Hospital and its outreach program in Greenville. This link, paradoxically, helped the judge justify the heavy reliance upon

123. Collin County patient hearings are generally held in Wichita Falls. *See* text accompanying notes 111-16 *supra*.

124. Examination by two physicians is required before a commitment hearing may be had. TEX. REV. CIV. STAT. ANN. art. 5547-32(a) (Vernon 1958).

the state hospital for most cases formally brought to his court. Thus, many citizens received care outside their home county.

VI. TRENDS IN THE USE OF ALTERNATIVES TO STATE HOSPITALIZATION

The courtroom observations and interviews on which this study is based revealed that rural counties rarely considered or used alternatives to state hospitalization. In Dallas County, however, alternatives to state hospitalization were considered and explored with greater frequency. To determine whether these observations are representative of the practice in each county and therefore a valid measure of the impact of section 38(c), we sampled records of commitment proceedings in each county for the past six years and recorded case dispositions. The six years sampled included the three years immediately prior to the passage of section 38(c) and the three years after its passage. This sample revealed that the statutory change permitting the judge to commit patients to alternative treatment resources had no impact in the two rural counties.¹²⁵ Few alternatives to state hospitalization were used in the three years prior to enactment of section 38(c), and few alternatives were used thereafter. One reason for the lack of impact of section 38(c) in rural counties is the unavailability of alternatives to hospitalization. The lack of alternatives is only one reason, however, since alternatives to state hospitalization were seldom considered at the hearings in Collin and Hunt Counties; in some cases key personnel in these counties seemed unaware of the availability of local community alternatives. Thus, instead of utilizing local facilities to the maximum extent and availing themselves of the unique intangible resources that can be tapped in a rural community,¹²⁶ these counties failed to make the most of what was available.

Arguably, it may be that the protective and tolerant nature of small communities means that cases are quite serious by the time they reach official attention. If so, perhaps state hospitalization is the only practical alternative in these cases. Although we could not directly measure the seriousness of the disorders from the information contained in the court records, those records do include the patient's diagnosis, an indirect indicator of a case's seriousness. Tabulation of the diagnoses of cases in the commitment system in the three counties reveals that the diagnoses were roughly equivalent.¹²⁷ In only one category, alcohol and drug abuse problems, was there a large difference, with Hunt County having a greater proportion of these cases. Thus, it may be inferred from these similar diagnoses that the degree of patient disorder did not vary from county to county. Moreover, the extensive screening that occurred in Dallas County should eliminate nonserious cases from the hearing process. Three major

125. See Appendices B & D.

126. See Bachrach, *Deinstitutionalization of Mental Health Services in Rural Areas*, 28 HOSPITAL & COMMUNITY PSYCH. 669 (1977).

127. See Appendix E.

screening points occurred prior to the hearing: at the warrant stage by the mental health screening staff and the judge, at Parkland Hospital's psychiatric emergency room, and at the Mental Diagnostic Center. The likely result of this type of screening would be to screen out the less serious cases. It is therefore unlikely that case seriousness was what prevented the use of alternatives in rural counties.

In Dallas County, there was a shift in case disposition coincidental with the passage of section 38(c). State and private hospital commitments in Dallas dropped from fifty percent of all cases processed in the three years prior to passage to about thirty-five percent of all cases processed in the three years after the passage of section 38(c).¹²⁸ Another study of all Dallas Mental Diagnostic Center cases from September 1973 to February 1977 found a similar decrease in hospital commitments following the enactment of section 38(c).¹²⁹

Although the passage of section 38(c) coincides with the increased use of alternatives to state hospitalization in Dallas County, there were other factors contributing to this trend. Coincidental with the increased use of alternatives was Dallas's acquisition of a new judge assigned to civil commitment cases. This individual has taken an active role in the mental health system. Observations of the center meetings and interviews with participating attorneys indicate that the new judge has played a major role in shaping the system.

Moreover, shortly after the passage of section 38(c) a mental health screening staff was established to screen applications for hospitalization at the warrant stage. Dallas County also recently acquired the use of the Hillside Center where the Medical Diagnostic Center and other in-patient psychiatric services are now provided. Although section 38(c) did not require this acquisition of the Hillside Center or the creation of a screening service, these occurrences reflect a local attitudinal change occurring at or shortly after the passage of section 38(c). Through the use of the Hillside facility, short-term local in-patient psychiatric hospitalization, referred to as a community services commitment (CSC), can now occur followed by local out-patient care. If the proposed patient stabilizes sufficiently during the prehearing observation, community services out-patient commitment may be used.¹³⁰

At the present time the criteria for admission to one of the community service treatment programs are (1) availability of space in the desired program, (2) willingness of the patient to cooperate, and (3) adequate family support to assure that alternative treatment was carried through by the patient. Our observations and interviews show that these procedures limited the extent to which alternatives were explored in the court hearing and

128. See Appendix C.

129. S. Kirk, *The Effect of a Community Commitment Law on Commitments to Hospitals* (unpublished paper at Dallas County Mental Health Mental Retardation Center, Dallas, Texas).

130. Had this same approach been attempted in 1973, prior to the passage of art. 5547—38(c), the same facilities and supporting services would not have been available.

utilized by the court. Since the Medical Diagnostic Center personnel would not recommend those who contested their commitments for CSC placement, and the judge was unwilling to order a patient into a program in the face of staff opposition, contested cases resulted either in hospitalization or dismissal.¹³¹ Twenty-five percent of the uncontested cases ended up as CSC placements. None of the ninety-seven contested cases in our survey ended in CSC placement, although four ended in dismissal with the proviso that the patient seek voluntary treatment. Importantly, in these four cases, no commitment was made to any program. In short, section 38(c) was not used in contested court cases during our observational period.

An additional factor to be considered in evaluating the impact of section 38(c) is the national trend away from long-term institutional care and toward the use of local treatment alternatives.¹³² This shift was spurred locally by the filing of a "right to treatment" lawsuit against a Texas state mental hospital.¹³³ One response by the hospital to suits such as this was an attempt to decrease the patient load and thereby improve staff—patient ratios, which are frequently used as a benchmark for measuring treatment efforts in such litigation.¹³⁴

One consequence of the trend away from long-term commitments is that certain patients now have more frequent contacts with the judicial system concerning their involuntary hospitalization. Previously these individuals might have been committed to a single lengthy hospitalization; they may now be subject to release and subsequent rehospitalization for shorter time periods. Whether this process is more therapeutic, economical, or efficient is beyond the scope of this study.

It must also be recognized that the procedural results accomplished by a section 38(c) commitment in Dallas could have been accomplished prior to the passage of section 38(c). Patients in Dallas County are never ordered to utilize a particular alternative to hospitalization following a contested hearing. Instead they must "volunteer." The purpose of a section 38(c) commitment in these instances is to provide an additional incentive for the patient to adhere to the treatment regime. This same effect could have been accomplished before section 38(c) through an agreement with the pa-

131. See Appendix F. In order to check the representativeness of the data derived from our courtroom observations, the data in Appendix F were compared to a quarterly report from the Medical Diagnostic Center covering Apr. 1 to June 30, 1979. Although this time period was not the same as our observations, the proportions of various dispositions were comparable. For example, 57% of all cases from May 29, 1979, to Aug. 2, 1979, the period of our observation, resulted in hospitalization of some type; in the Medical Diagnostic Center report 55% of the cases resulted in hospitalization. Thirty-three percent of the cases observed resulted in alternative community programs, compared to the Medical Diagnostic Center report of 30%. We found 10% of cases dismissed, while Medical Diagnostic Center data for the earlier period reported that 15% were dismissed.

132. Greenblatt & Glazier, *The Phasing Out of Mental Hospitals in the United States*, 132 AM. J. PSYCH. 1135, 1135 (1975).

133. See *Jenkins v. Cowley*, No. CA 3-74-394 (N.D. Tex., filed Dec. 10, 1974).

134. See, e.g., *Wyatt v. Stickney*, 344 F. Supp. 387 (M.D. Ala. 1972), *modified sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974).

tient to continue the proceedings for a finite time, with the understanding that if the patient follows the prescribed regime, the case will be dismissed.¹³⁵ Although this approach might have proven problematic if a subsequent attempt was made to commit such a patient in Dallas County, unsuccessful section 38(c) commitments are handled as initial commitments.¹³⁶ Thus, if unsuccessful continuances were also handled as initial commitments, any problems concerning the absence of statutory authority to permit a continuance under these circumstances could be overcome.

VII. CONCLUSIONS

The most basic requirement for the use of less drastic alternatives is the existence of alternatives. Far too frequently this summer we observed patients sent to the state hospital because a local alternative did not exist, and not because the patient required the services of the state hospital. The first priority in any attempt to utilize alternatives to state hospitalization must therefore be the creation and funding of local alternatives to state hospitalization.¹³⁷ This Article is not an appropriate forum to provide a shopping list of mental health resources that particular communities require. Comprehensive health planning is best accomplished in other settings. Certain general observations can be made, however. The absence of local, short-term psychiatric hospitalization capacity in the rural counties we observed often resulted in the immediate transfer from the community of residents with behavioral problems. Perhaps a county that utilizes the civil commitment process should be required, as the price of participating in the system, to provide adequate local pre-hearing and short-term in-patient psychiatric treatment facilities. Such a requirement might require that

135. For examples of this approach, see Peters, Teply, Wunsch & Zimmerman, *Administrative Civil Commitment: The Ins and Outs of the Nebraska System*, 9 CREIGHTON L. REV. 266, 275 (1975); Wexler & Scoville, *supra* note 16, at 77.

136. This procedure avoids a serious due process problem since the statute makes no provision for the procedures necessary to revoke an art. 5547—38(c) commitment. *Accord*, Lewis v. Donahue, 437 F. Supp. 112 (W.D. Okla. 1977); Meisel v. Kremens, 405 F. Supp. 1253 (E.D. Pa. 1975); Government of the United States *ex rel.* Shaban v. Essen, 386 F. Supp. 1042 (E.D.N.Y. 1974), *aff'd*, 516 F.2d 897 (2d Cir. 1975); *cf.* Gagnon v. Scarpelli, 411 U.S. 778 (1973) (due process requires preliminary and final hearings for revocation of probation); Morrissey v. Brewer, 408 U.S. 471 (1972) (parole revocation required informal hearing and other minimum due process safeguards).

137. It has been held that the doctrine of the least restrictive alternative requires not only examination of existing alternatives, but also the duty to see that such alternative facilities exist. Dixon v. Weinberger, 405 F. Supp. 974 (D.D.C. 1975). *See also* Morales v. Turman, 383 F. Supp. 53, 125 (E.D. Tex. 1974), *rev'd on other grounds*, 535 F.2d 864 (5th Cir. 1976) (en banc) in which the court noted in its decision concerning the State of Texas's obligation to investigate the least restrictive form of care of juveniles that:

The state may not circumvent the Constitution by simply refusing to create any alternatives to incarceration; it must act affirmatively to foster such alternatives as now exist only in rudimentary form (foster homes, supervised probation and parole), and to build new programs suited to the needs of the hundreds of its children that do not need institutional care (*e.g.*, group homes, halfway houses, day care programs, outpatient clinics, home placements with close supervision). The Constitution of the United States and the laws of the State of Texas require no less of the defendants.

counties with populations in excess of a certain figure provide such a facility, while permitting cooperative ventures by smaller counties.

Another factor in the failure to utilize alternatives is the failure of key personnel within the system to understand what alternatives exist and how those alternatives might be effective in the treatment of mental illness. Both judges and lawyers could benefit greatly from educational programs dealing with mental disorder, its diagnosis, and the efficacy of various forms of treatment, as well as with current developments in mental health law. Knowledge of the alternatives does not insure their effective use, however. Attorneys must be encouraged by the court to play an active role in commitment proceedings. Attorneys must be given adequate notice of the proceedings and reasonable compensation to justify thorough preparation of the case. Requiring the staff to make its recommendations earlier in time would help accomplish this goal. One unfortunate consequence of an early recommendation requirement is that the social workers, psychologists, and psychiatrists may be rushed in their preliminary preparation of the case. One way to avoid this rush and to permit earlier recommendations would be to detain the proposed patient for a longer time prior to hearing. In addition to the due process implications of such an increased deprivation of liberty prior to a hearing, however, this pre-hearing detainment would require the use of beds utilized for in-patient commitments. Thus, a decision to require early notice involves a balancing of the reliability of the initial commitment decision against the use of these same facilities for post-commitment local hospitalization.

In addition to providing the time that mental health professionals require to perform their jobs properly, the mental health professionals must also be made aware of treatment alternatives. Our interviews and observations revealed that many mental health professionals participating in the civil commitment process were either unaware of existing alternatives or simply failed to consider potentially viable alternatives. Several steps are necessary to correct this problem. First, programs highlighting the existing spectrum of traditional and nontraditional local mental health resources should be conducted. In addition, mental health professionals must be encouraged to scrutinize more carefully their own recommendations and those of their colleagues. Finally, the reasons for the recommendations of these mental health professionals must be carefully explained at trial; the supporting analysis and, in particular, the reason for excluding alternatives must be described to the court.

In Dallas County the testifying psychiatrist is expected to address and exclude the use of alternatives to hospitalization before commitment is ordered. This practice does not exist in Collin or Hunt Counties. Arguably, the state may be required by constitutional principles to exclude the practicality of alternatives to state hospitalization before the court may commit a patient to the state hospital.¹³⁸ *Lake v. Cameron*,¹³⁹ the first case to reach

138. See notes 13-24 *supra* and accompanying text.

139. 364 F.2d 657 (D.C. Cir. 1966).

this conclusion, involved the construction of a District of Columbia statute. The relevant portions of that statute, interpreted in 1966 to require the government to exclude alternatives to hospitalization, provide: "the court may order [the patient's] hospitalization for an indeterminate period, or order any other alternative course of treatment which the court believes will be in the best interests of the person or of the public."¹⁴⁰ The language chosen by the Texas Legislature for section 38(c) is so remarkably similar¹⁴¹ to the language of the District of Columbia Code interpreted in *Lake*, nine years prior to the passage of section 38(c), that it may be argued convincingly that the Texas Legislature intended to require the same result in Texas as the District of Columbia Code required in *Lake*.

Moreover, if, as a matter of policy, the state wishes to encourage the use of alternatives to state hospitalization, it must encourage the addressing of these issues in court. This policy is too important to be left to local practice. If the practicality of less drastic alternatives is to be an issue, one of the parties must be assigned the burden of production and persuasion on this issue. An allocation of these evidentiary burdens to the state would reflect a policy that state hospitalization should be used only after a finding that no practical alternatives exist. Further, because of the state's access to social workers, psychologists, and psychiatrists, it has greater access to information concerning the availability of alternatives and their appropriateness in particular cases than has a prospective patient.¹⁴² The Mental Health Code should therefore be amended to require the state to address and exclude alternatives to hospitalization as an element of its *prima facie* case. The state should be required to meet the same standard of persua-

140. *Id.* at 661.

141. "[T]he court may order the proposed patient to submit to other treatment, observation, or care as may be found by the court to be likely to promote the welfare or protection of the proposed patient and the protection of others." TEX. REV. CIV. STAT. ANN. art. 5547—38(c) (Vernon Supp. 1980).

142. Closely related to the state's greater access to information on the appropriateness of particular alternatives is the patient's access to independent experts to evaluate and testify on the appropriateness of particular alternatives. Given the court's reliance upon expert testimony, the patient's ability to persuade the court that an alternative is appropriate will likely turn on the patient's ability to produce favorable expert testimony. There is little dispute that independent psychiatric examinations may lead to different conclusions than those performed by the examining psychiatrist. Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693 (1974). Thus, the mere fact that the state's psychiatrist concludes that alternatives are not appropriate in a certain case does not mean that another competent psychiatrist would reach the same conclusion. Because it is the court, and not the psychiatrist, who must ultimately decide whether state hospitalization, alternative care, or dismissal should be ordered, the patient's access to an independent expert is crucial.

The typical civil commitment patient is indigent, thus often only a court-appointed and court-paid expert will permit the patient access to expert testimony. Although this exact issue has not been addressed in Texas, in the criminal context Texas courts have not found the appointment of such an expert to be required by the Texas Constitution. *Crain v. State*, 394 S.W.2d 165, 167-68 (Tex. Crim. App. 1964), *cert. denied*, 382 U.S. 853 (1965). Other jurisdictions, however, have required the appointment of independent experts in civil commitment proceedings. *E.g.*, *In re Gannon*, 123 N.J. Super. 104, 301 A.2d 493 (Somerset County Ct. 1973). Even in the absence of a constitutional requirement, the legislature could require the appointment of such experts to increase the use of alternatives to state hospitalization and to reduce the courts' dependence on the state's psychiatrist.

sion it is required to meet to commit a patient, *i.e.*, by clear and convincing evidence.¹⁴³

The passage of section 38(c) must not be viewed as the final battle for mental health advocates. There is cogent evidence that a change in the law can have a beneficial effect on the disposition of commitment cases. Yet our study of its impact reinforces the conclusion that unless the alternative mental health services exist and key people are aware of their existence and efficacy, section 38(c) may be merely a hollow promise of community mental health care.

143. *Addington v. Texas*, 99 S. Ct. 180, 60 L. Ed. 2d 323 (1979).

Appendix A

County (County Seal)	Population 1970*/1976**	Rural Pop. (%) Nonfarm/Farm*	Black/Spanish*	Median Income*	Fiscal Year 1978 Number of Direct Hospital Admissions#	Fiscal Year 1978 Involuntary Commitments#
Collin (McKinney)	66,920	35.2	4,555	4,193	86	34
Cooke (Gainsville)	23,471	26.9	1,022	499	54	37
Dallas (Dallas)	1,327,320	0.9	220,357	88,652	1,895	910
Denton (Denton)	75,633	28.9	4,583	2,973	139	72
Ellis (Waxahachie)	46,823	38.0	8,602	4,040	57	28
Fannin (Bonham)	22,705	52.1	2,163	—	38	29
Grayson (Sherman)	83,223	25.7	6,591	1,436	133	60
Henderson (Athens)	26,466	53.7	4,567	455	55	48
Hill (Hillsboro)	22,596	50.9	2,882	1,443	23	14
Hood (Granbury)	6,368	84.0	—	—	14	7
Hunt (Greenville)	47,916	27.2	6,432	1,378	116	60
Johnson (Cleburne)	45,769	40.3	1,391	1,367	46	26
Kaufman (Kaufman)	32,392	34.3	7,945	1,129	129	77
Navarro (Corsicana)	31,150	27.6	6,786	898	82	45

Parker (Weatherford)	33,888	34,483	44.8	12.6	—	1,354	8,412	38	23
Rains (Emory)	3,752	4,441	74.5	25.5	—	—	5,287	9	4
Rockwall (Rockwall)	7,046	9,426	45.2	6.3	1,013	—	9,092	24	6
Somervell (Glen Rose)	2,793	3,501	80.0	20.0	—	—	6,890	8	4
Tarrant (Ft. Worth)	716,316	760,613	2.7	0.5	80,851	42,960	10,218	592	253
Van Zandt (Canton)	22,155	27,193	68.6	19.8	1,376	—	6,776	84	45
Wise (Decatur)	19,687	21,763	43.4	20.3	—	467	7,764	35	23

Sources

* 1970 Census of Population

** Current Population: Population Estimates and Projections (1976)

Texas Dept. of Mental Health and Mental Retardation Data Book 1978

Appendix B

Court Disposition of Mental Illness Cases
by Year from 1974* to 1978 in Collin County
(Percentages in Parentheses)

	1974	1975	1976	1977	1978
Hospital Commitment for 90 days (state or private)	20 (91)	16 (80)	13 (82)	9 (56)	13 (57)
Order of Protective Custody	0 (-)	2 (10)	1 (6)	0 (-)	2 (9)
Commitment to Alternative Treatment	0 (-)	0 (-)	0 (-)	1 (6)	0 (-)
Dismiss to Treatment	0 (-)	0 (-)	1 (6)	0 (-)	1 (4)
Dismissal	2 (9)	2 (10)	1 (6)	6 (38)	7 (30)
Total Cases**	22	20	16	16	23

* Records were not available due to lack of effective recording and retrieval methods for court cases handled in 1973.

** The total sample was 100 cases. Three cases did not contain information on case disposition and thus were excluded from the table.

Appendix C

Court Disposition of Mental Illness Cases
by Year from 1973 to 1978* in Dallas County
(Percentages in Parentheses)

	1973	1974	1975	1976	1977	1978
Hospital Commitment for 90 days (state or private)	25 (52)	25 (50)	26 (54)	18 (38)	14 (29)	18 (38)
Order of Protective Custody	0 (-)	0 (-)	0 (-)	0 (-)	2 (4)	0 (-)
Commitment to Alternative Treatment	0 (-)	0 (-)	0 (-)	0 (-)	4 (18)	15 (32)
Dismiss to Treatment	9 (19)	9 (18)	5 (10)	4 (8)	4 (8)	2 (4)
Dismissal	14 (29)	16 (32)	17 (36)	26 (54)	25 (51)	12 (26)
Total Cases*	48	50	48	48	49	47

* The total sample was 298 cases. Eight cases did not contain information on case disposition and thus were excluded from the table.

Appendix D

Court Disposition of Mental Illness Cases
by Year from 1973 to 1978* in Hunt County
(Percentages in Parentheses)

	1973	1974	1975	1976	1977	1978
Hospital Commitment for 90 days (state or private)	26 (96)	15 (71)	15 (66)	22 (96)	15 (54)	18 (78)
Order of Protective Custody	0 (-)	0 (-)	4 (17)	1 (4)	4 (14)	0 (-)
Commitment to Alternative Treatment	0 (-)	0 (-)	0 (-)	0 (-)	0 (-)	0 (-)
Dismiss to Treatment	0 (-)	1 (5)	0 (-)	0 (-)	0 (-)	0 (-)
Dismissal	1 (4)	5 (24)	4 (17)	0 (-)	9 (32)	5 (22)
Total Cases*	27	21	23	23	28	23

* The total sample was 147 cases. Two cases did not contain information on case dispositions and thus were excluded from the table.

Appendix E

Type of Diagnosis in Mental Illness
Commitment Proceedings in Three Counties
(Percentage in Parentheses)

Diagnosis	Collin	Dallas	Hunt
Mental Retardation	3 (3.0)	8 (2.7)	3 (2.0)
Other Organic Conditions	6 (6.0)	30 (10.1)	12 (8.2)
Schizophrenia	40 (40.0)	130 (43.6)	44 (29.9)
Manic-Depressive; Suicidal	11 (11.0)	28 (9.4)	6 (4.1)
Neurosis	5 (5.0)	7 (2.3)	6 (4.1)
Personality Disorder	5 (5.0)	13 (4.4)	3 (2.0)
Alcohol; Drug Abuse	15 (15.0)	47 (15.8)	53 (36.1)
Sociopathic	2 (2.0)	2 (0.7)	3 (2.0)
No Information	13 (13.0)	33 (11.1)	17 (11.6)
Total Cases	100	298	147

Appendix F

Court Disposition by Degree of Contesting Hospitalization
for Dallas County, Summer 1979
(Percentage in Parentheses)

Disposition	Type of Case		Total
	Contested Cases	Uncontested Cases	
90-day Hospitalization (TSH and private)	65 (67.0)	120 (37.4)	185 (44.3)
Order of Protective Custody	16 (16.5)	11 (3.4)	27 (6.4)
Community Services Commitment	0 (-)	79 (24.6)	79 (18.9)
Dismiss for Treatment Elsewhere	4 (4.1)	34 (10.6)	38 (9.1)
Dismiss	6 (6.2)	27 (8.4)	33 (7.9)
Pass	6 (6.2)	50 (16.6)	56 (13.4)
	97	321	418

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